Senate Business, Professions and Economic Development Committee
COMMITTEE BILL: PROPOSED LEGISLATION

Note: Submit the completed form to the Committee electronically by email and attach any additional information or documentation as necessary.

DRAFT

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SUMMARY

SB 1436 *(statutes of 2022)* addressed basic respiratory tasks and services that could be provided by Licensed Vocational Nurses (LVNs) and provided a carve out for patients in home care. Since the passage of SB 1436, the Respiratory Care Board (Board) has been alerted to other facility types and activities that necessitate a carve out due to the lack of/insufficient reimbursement for respiratory care practitioners authorized to provide respiratory care services. This proposal aims to provide a carve out for other types of facilities and explore establishing reimbursement for respiratory services.

IDENTIFICATION OF PROBLEM

SB 1436 *(statutes of 2022)* resolved a serious and long-standing consumer safety issue regarding the safe practice of respiratory care in health care facilities by allowing the Board to identify the respiratory tasks and services that could be safely delivered by licensed vocational nurses (LVNs). SB 1436 also recognized that health care reimbursement and the health care delivery model that has evolved since the 1990s, made it unfeasible to include home care and as such, an exemption for home health agencies was included in SB 1436.

The request to carve out home care came forth at the behest of many stakeholders, including patients and family members in the home, where the quality of life at home and fear of being re-institutionalized, far outweighed concerns of regulation of competency and quality of care, opting instead for in-house training of LVNs to perform specific tasks. However, nearly all stakeholders acknowledge that the lack of reimbursement for respiratory services by respiratory care practitioners is the ultimate roadblock to their access to quality care in home and community-based settings.

Notwithstanding, without reimbursement and to avoid a catastrophic-level impact to patients in the home, the Board recommended the exemption provided to home health agencies that allows LVNs to perform respiratory tasks beyond basic tasks and services with the caveat of including training guidelines.

Home and Community-Based Facilities

Since the passage of SB 1436, it has come to the Board's attention that there are other licensed "home and community based" facilities and patients in the same predicament: Lack of respiratory care practitioner reimbursement with fears of patients being re-institutionalized or losing access to daily living services. Specifically, services provided for transporting and/or overseeing care of patients during daily activities, such as an outing, attending school, or providing a few hours of relief for parents in homecare, and care provided at the following facilities:

Home care and community-based facilities cannot afford respiratory care practitioners to provide respiratory care services and patients fear being re-institutionalized and/or losing access to daily living services.

Licensed Adult Day Health Care Facilities (approx. 282 facilities)

An organized day program of therapeutic, social, and skilled nursing health activities and services provided pursuant to this chapter to elderly persons or adults with disabilities with functional impairments, either physical or mental, for the purpose of restoring or maintaining optimal capacity for self-care. Provided on a short-term basis, adult day health care serves as a transition from a health facility or home health program to personal independence. Provided on a long-term basis, it serves as an alternative to institutionalization in a long-term health care facility when 24-hour skilled nursing care is not medically necessary or viewed as desirable by the recipient or his or her family. (Ref: Health and Safety Code section 1570.7(a)).

Licensed Pediatric Day Health & Respite Care Facilities (approx. 18 facilities)

A facility that provides an organized program of therapeutic social and day health activities and services and limited 24-hour inpatient respite care to medically fragile children 21 years of age or younger, including terminally ill and technology dependent children. (Ref: Health and Safety Code section 1760.2(a)).

Licensed Congregate Living Health Facilities (approx. 213 facilities)

(1) "Congregate living health facility" means a residential home with a capacity, except as provided in paragraph (4), of no more than 18 beds, that provides inpatient care, including the following basic services: medical supervision, 24-hour skilled nursing and supportive care, pharmacy, dietary, social, recreational, and at least one type of service specified in paragraph (2). The primary need of congregate living health facility residents shall be for availability of skilled nursing care on a recurring, intermittent, extended, or continuous basis. This care is generally less intense than that provided in general acute care hospitals but more intense than that provided in skilled nursing facilities. (Ref: Health and Safety Code section 1250(i)).

Licensed Intermediate Care Facilities (approx. 1115 facilities)

- Intermediate Care Facility (13 Licensed Facilities)
  A health facility that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care, but who do not require availability of continuous skilled nursing care. (Ref: Health and Safety Code section 1250(d)).
- Intermediate Care Facility /Developmentally Disabled (14 Licensed Facilities)
  A facility that provides 24-hour personal care, habilitation, developmental, and supportive health services to persons with developmental disabilities whose primary need is for developmental services and who have a recurring but intermittent need for skilled nursing services. (Ref: Health and Safety Code section 1250(g)).
- Intermediate Care Facility/Developmentally Disabled-Continuous Nursing Care (6 Licensed Facilities)
  A homelike facility with a capacity of four to eight, inclusive, beds that provides 24-hour personal care, developmental services, and nursing supervision for persons with developmental disabilities who have continuous needs for skilled nursing care and have been certified by a physician and surgeon as warranting continuous skilled nursing care. The facility shall serve medically fragile persons who have developmental disabilities or demonstrate significant developmental delay that may lead to a developmental disability if not treated. (Ref: Health and Safety Code section 1250(m)).
- Intermediate Care Facility/Developmentally Disabled-Habilitative (703 Licensed Facilities)
  A facility with a capacity of 4 to 15 beds that provides 24-hour personal care, habilitation, developmental, and supportive health services to 15 or fewer persons with developmental disabilities who have intermittent recurring needs for nursing services but have been certified by a physician and surgeon as not requiring availability of continuous skilled nursing care. (Ref: Health and Safety Code section 1250(e)).
- Intermediate Care Facility/Developmentally Disabled - Nursing (419 Licensed Facilities)
  A facility with a capacity of 4 to 15 beds that provides 24-hour personal care, developmental services, and nursing supervision for developmentally disabled persons who have intermittent recurring needs for skilled nursing care but have been certified by a physician and surgeon as not requiring continuous skilled nursing care. The facility shall serve medically fragile persons who have developmental disabilities or demonstrate significant developmental delay that may lead to a developmental disability if not treated. (Ref: Health and Safety Code section 1250(h)).

Skilled Nursing Services and Reimbursement

At some point after the establishment of many home and community-based facilities in the 1990s, regulators and the industry erroneously interpreted "skilled nursing services" to include respiratory care tasks and services identified in sections 3702 and 3702.5 of the Business and Professions Code (B&P) - - yet the mandated nursing-patient ratios exclude respiratory care practitioners from being counted toward meeting those ratios.

At some point, regulators and the industry erroneously interpreted "skilled nursing services" to include respiratory care tasks and services - - yet the mandated nursing-patient ratios exclude respiratory care practitioners from being counted toward meeting those ratios.

Reimbursement for respiratory therapy services is nearly silent in laws and regulations for home and community-based settings. Regulations were found within Title 22, Division 3, Subdivision 1, California Medical Assistance Program, Chapters 3 and 8, that specifically provide definitions and identify services for reimbursement—respiratory therapy is erroneously omitted.

§ 58013. Home Health Care Services.
"Home Health Care Services" means skilled nursing or other professional services in the residence, including, but not limited to, part-time and intermittent skilled nursing services, home health aide services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.

§ 51523. Home Health Agency Services.
(a) An approved home health agency shall be reimbursed in accordance with the maximum rates as shown below. However, in no case shall the service billed exceed charges made to the general public for the provision of similar services.

Procedure Code	Per Visit Allowance	Max. Rates
Z6900	Nursing Services	$74.86
Z6902	Home Health Aide Services	$45.75
Z6904	Physical Therapy Services	$68.84
Z6906	Occupational Therapy Services	$71.36
Z6908	Speech Therapy Services	$78.43
Z6910	Medical Social Services	$96.22
Z6914	Case Evaluation and Initial Treatment Plan	$30.13
Z6916	Monthly Case Evaluation Extension of Treatment Plan	$15.19
Z6918	Unlisted Services	By Report
Z6920	Early Discharge Visit	$74.86

Home Medical Device Retail (HMDR) Facilities

The regulation of HMDR Facilities began in or about 2000 and is overseen by the California Department of Public Health. HMDR facilities supply prescription medical devices or durable medical equipment for use in home and community-based settings to treat acute or chronic illnesses or injuries. The HMDR program also licenses exemptees that are required to be on staff in lieu of a pharmacist at facilities selling prescription medical devices as described under California and Federal medical device laws. The Board and the HMDR program worked together and met numerous times over several years, to ensure the new laws and regulations were interpreted and enforced correctly and in the interest of consumer safety.

HMDRs are the key component and quite possibly the missing link to establishing patient safeguards for respiratory care in home and community-based settings. Most home and community-based respiratory patients rely on equipment, such as ventilators, issued by a HMDR facility. HMDR facilities, via regulations promulgated by the Board[1], require that only RCPs are permitted to provide respiratory care including mask fitting, equipment set-up and connection, performing clinical assessments, education, and follow-up services (as needed or at the request of the patient and/or the patient's family/care provider).

For patients where family members are the sole health care providers and/or do not utilize a home health agency, RCPs employed at HMDR facilities serve as the only "bridge" between the patient and the doctor in addressing problems. The RCP at the HMDR facility resolves issues to avoid additional doctor or emergency room visits.

However, the HMDR facility reimbursement model is solely based on equipment reimbursement. Reimbursement for the installation, setup, or instruction in the use of equipment is currently limited to the reimbursement for the equipment itself.

Given that home care services do not make staffing an RCP 24 hours a day for one patient feasible, relying on the services of the HMDR facility RCP are essential.

Respiratory Care Scope of Practice

Following are the three sections of the Business and Professions Code, Division 2, Chapter 8.3 that define the respiratory care scope of practice. Section 3702.5 states the Board is the sole authority to define and interpret the practice of respiratory care.

> **3702.**
> (a) Respiratory care as a practice means a health care profession employed under the supervision of a medical director in the therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities which affect the pulmonary system and associated aspects of cardiopulmonary and other systems functions, and includes all of the following:

[1] Title 16. Professional and Vocational Regulations, Division 13.6. Respiratory Care Board of California, Article 6. Scope of Practice, § 1399.360. Unlicensed Personnel Services; Home Care.

(1) Direct and indirect pulmonary care services that are safe, aseptic, preventive, and restorative to the patient.

(2) Direct and indirect respiratory care services, including, but not limited to, the administration of pharmacological and diagnostic and therapeutic agents related to respiratory care procedures necessary to implement a treatment, disease prevention, pulmonary rehabilitative, or diagnostic regimen prescribed by a physician and surgeon.

(3) Observation and monitoring of signs and symptoms, general behavior, general physical response to respiratory care treatment and diagnostic testing and (A) determination of whether such signs, symptoms, reactions, behavior, or general response exhibits abnormal characteristics; (B) implementation based on observed abnormalities of appropriate reporting or referral or respiratory care protocols, or changes in treatment regimen, pursuant to a prescription by a physician and surgeon or the initiation of emergency procedures.

(4) The diagnostic and therapeutic use of any of the following, in accordance with the prescription of a physician and surgeon: administration of medical gases, exclusive of general anesthesia; aerosols; humidification; environmental control systems and baromedical therapy; pharmacologic agents related to respiratory care procedures; mechanical or physiological ventilatory support; bronchopulmonary hygiene; cardiopulmonary resuscitation; maintenance of the natural airways; insertion without cutting tissues and maintenance of artificial airways; diagnostic and testing techniques required for implementation of respiratory care protocols; collection of specimens of blood; collection of specimens from the respiratory tract; analysis of blood gases and respiratory secretions.

(5) The transcription and implementation of the written and verbal orders of a physician and surgeon pertaining to the practice of respiratory care.

(b) As used in this section, the following apply:

(1) “Associated aspects of cardiopulmonary and other systems functions” includes patients with deficiencies and abnormalities affecting the heart and cardiovascular system.

(2) “Respiratory care protocols” means policies and protocols developed by a licensed health facility through collaboration, when appropriate, with administrators, physicians and surgeons, registered nurses, physical therapists, respiratory care practitioners, and other licensed health care practitioners.

3702.5.
Except for the board, a state agency may not define or interpret the practice of respiratory care for those licensed pursuant to this chapter, or develop standardized procedures or protocols pursuant to this chapter, unless authorized by this chapter or specifically required by state or federal statute. The board may adopt regulations to further define, interpret, or identify all of the following:

(a) Basic respiratory tasks and services that do not require a respiratory assessment and only require manual, technical skills, or data collection.

(b) Intermediate respiratory tasks, services, and procedures that require formal respiratory education and training.

Except for the board, a state agency may not define or interpret the practice of respiratory care for those licensed pursuant to this chapter, or develop standardized procedures or protocols…

(c) Advanced respiratory tasks, services, and procedures that require supplemental education, training, or additional credentialing consistent with national standards, as applicable.

3702.7.
The respiratory care practice is further defined and includes, but is not limited to, the following:

(a) Mechanical or physiological ventilatory support as used in paragraph (4) of subdivision (a) of Section 3702 includes, but is not limited to, any system, procedure, machine, catheter, equipment, or other device used in whole or in part, to provide ventilatory or oxygenating support.

(b) Administration of medical gases and pharmacological agents for the purpose of inducing conscious or deep sedation under physician and surgeon supervision and the direct orders of the physician and surgeon performing the procedure.

(c) All forms of extracorporeal life support, including, but not limited to, extracorporeal membrane oxygenation (ECMO) and extracorporeal carbon dioxide removal (ECCO2R).

(d) Educating students, health care professionals, or consumers about respiratory care, including, but not limited to, education of respiratory core courses or clinical instruction provided as part of a respiratory educational program and educating health care professionals or consumers about the operation or application of respiratory care equipment and appliances.

(e) The treatment, management, diagnostic testing, control, education, and care of patients with sleep and wake disorders as provided in Chapter 7.8 (commencing with Section 3575).

Title 22, Conflicting Terms – Respiratory Care Practitioner

Throughout Title 22 there are conflicting terms for respiratory care practitioner. The correct reference is “Respiratory Care Practitioner,” but throughout Title 22, references are made to respiratory technician, respiratory therapist or a derivation thereof. Lack of consistency creates confusion for readers.

SUMMARY

On the tail of the practice of respiratory care emerging in the 1980s, many home and community-based types of health care settings emerged or shifted. From a very high-level overview, this appears to be the crux of why home and community-based health care continues to evolve, neglecting to recognize RCPs and the respiratory care scope of practice, as well as their expertise in managing all things cardiopulmonary.

There are three primary factors of regulatory neglect, that have led to the current problem of Home and Community-Based patients facing an immediate and catastrophic-level impact and disruption to their lives, including fear of being reinstitutionalized:

1) The misunderstanding by the industry that respiratory care is a skilled nursing service. Many, not all, in the various industries have adopted an evolved definition of “nursing services” to include services in the respiratory care scope of practice, in large part due to many state regulatory agencies erroneous interpretation and enforcement.

2) Nurse-to-patient ratios established years ago, incentivized the evolution of the definition of "skilled nursing services" to include respiratory care tasks and services erroneously. The California Nurses Association (CNA) is on record as stating respiratory care services are NOT skilled nursing services. Because RCPs providing respiratory care services are not counted toward this ratio, and there is no other fair reimbursement amounts for respiratory services in home and community-based settings, it is convenient for some providers to claim respiratory care is included in nursing services in order to meet the nurse-to-patient ratio in the most fiscally prudent manner. By applying this interpretation, patients are not receiving the required hours of skilled nursing services and unauthorized health care providers put their licenses at risk by performing tasks they are not fully trained, educated or competency tested to perform.

3) The lack of reimbursement OR reimbursement requirements and enforcement thereof, that requires RCPs or other qualified health care personnel be the actual providers of respiratory tasks and services. Establishing or increasing a reimbursement amount for a service is necessary, but failure to enforce the use of qualified providers, will not eliminate the use of providers with less or no education, training, and competency testing from performing tasks above and outside their scope of practice.

PROPOSED SOLUTION

This proposed legislation will provide carve outs and establish a means for LVNs to obtain approved education and training to legally provide respiratory care in home and community-based settings, while also requiring the California Department of Public Health and the California Department of Health Care Services to examine the issue of reimbursement and enforcement.

The Board is hopeful that it can improve consumer safety by establishing at a minimum, a requirement for an RCP to be on staff at all times for every six patients requiring respiratory care to provide oversight and/or perform the respiratory care functions and also fully utilize the RCPs staffed through HMDR facilities. Respiratory patients are often the most vulnerable of the home and community-based patient population with an overwhelming majority of those patients reliant upon Medi-Cal reimbursement.

Notwithstanding, the Board submits this legislative proposal that will further the exploration of discovering the root of the problem while ensuring patients are spared devastating life-altering impacts from government regulation in the interim.

PROGRAM BACKGROUND & LEGISLATIVE HISTORY

The enabling statute to license Respiratory Care Practitioners (RCPs) was signed into law in 1982, thus establishing the Respiratory Care Board of California. The first license was issued in 1985 through a grandfather provision that ended in 1987. The Board is mandated to protect the public from the unauthorized and/or unqualified practice of respiratory care and from unprofessional conduct by persons licensed to practice respiratory care.

The Board ensures that applicants meet the minimum education and competency standards and conducts a thorough criminal background check on each applicant prior to licensure. The Board also pursues discipline for violations of its Act. Over 45,000 licenses have been issued to date.

RCPs work most often in intensive care units (ICUs) and emergency departments, but are also commonly found in acute care settings, outpatient clinics, skilled nursing facilities, sleep clinics and home-health environments. In facilities that maintain critical care transport teams, RCPs are a preferred addition to all types of surface or air transport. RCPs work with patients of all ages from newborn infants to the elderly.

RCPs provide direct patient care, patient education, and care coordination. An RCP's responsibilities and competencies include:

- Clinical decisions that are data-driven and evidenced based.
- Involvement in research and adept at understanding the practical ramifications of published research.
- The use of sophisticated medical equipment and performance of complex therapeutic procedures and diagnostic studies.
- An in-depth understanding of human physiology and the ability to apply that knowledge in the workplace.
- Excellent teamwork skills, including effective communication when interacting with other health care providers.

RCPs are advanced-practice clinicians in airway management. They establish and maintain the airway during trauma and intensive care. RCPs also educate, diagnose, and treat people who are suffering from heart and lung problems. Specializing in the diagnosis and treatment of cardiopulmonary ailments, RCPs often collaborate with specialists in pulmonology and anesthesia in various aspects of clinical care. RCPs with advanced education or credentialing evaluate and treat patients with a great deal of autonomy under the direction of a pulmonologist.

RCPs in the United States are migrating toward a role with autonomy similar to the nurse practitioner, or as an extension of the physician like the physician assistant. RCPs are frequently utilized as complete cardiopulmonary specialists being utilized to place and manage arterial accesses along with peripherally inserted central catheters, administer medications or pharmacological agents for conscious sedation and serve as extracorporeal membrane oxygenation (ECMO) and extracorporeal life support (ECLO) specialists.

In the 1990s, a new and growing trend emerged in the health care industry. It was in in the mid-1990s that the Board became aware of the Board of Vocational Nursing and Psychiatric Technicians promoting the use of LVNs to manage ventilators and care for respiratory care patients. Since that time the Board has pushed back against this idea from a consumer safety standpoint, as demonstrated in the Board's 2021 Sunset Report. The effort to promote the use of LVNs to provide respiratory care aligns with many new or evolved community and home-based health care options that came about in the early 1990s.

Adult Day Health Care

- In 1978, AB 1611 was enacted making California the first state to pass legislation to make ADHC a specific licensure category and a Medi-Cal benefit. Licensure was limited to public or private, non-profit community organizations.
- In 1993, new policy was implemented (codified in 1995 via AB 1882) allowing residents of Intermediate Care Facilities/ Developmentally Disabled-Habilitative (ICF/DD-H) facilities to attend ADHC centers.
- Also in 1993, SB 2429 and SB 681, allowed the delivery of other types of adult day services operating under the ADHC license.
- In 1995, SB 1492 eliminated licensure restrictions and allowed individuals and for-profit entities to be licensed and certified as ADHC providers.

Licensed Pediatric Day Health & Respite Care

- In 1990, legislation was enacted *(AB 3413, Ch. 1227, Sec. 8. Statutes of 1990)* to establish the licensure of Licensed Pediatric Day Health & Respite Care facilities. Health and Safety Code, Section 1760.4 defines “Medically fragile” as means of having an acute or chronic health problem which requires therapeutic intervention and skilled nursing care during all or part of the day. Medically fragile problems include, but are not limited to, HIV disease, severe lung disease requiring oxygen, severe lung disease requiring ventilator or tracheostomy care, complicated spina bifida, heart disease, malignancy, asthmatic exacerbations, cystic fibrosis exacerbations, neuromuscular disease, encephalopathies, and seizure disorders. Yet there are no requirements or even suggestions that RCPs be part of the staffing personnel.

Licensed Congregate Living Health

- SB 331 (statutes of 1987) defined "Congregate living health facility" as a residential home with a capacity of no more than six beds, which provides inpatient care to mentally alert, physically disabled residents, who may be ventilator dependent, and which provides the following basic services: medical supervision, 24-hour skilled nursing and supportive care to residents, including ventilator assisted or dependent residents, all of whom would otherwise require long-term institutional care without this licensure classification and who no longer require care in an acute care facility, as determined by their physicians. This definition has been altered significantly since 1987 as noted earlier and as found in subdivision (i) of section 1250 of the Health and Safety Code.

Intermediate Care

- In 1987, SB 331 defined four of the five types of intermediate care facilities and no substantive changes have been made since:

  Intermediate care facility

  Intermediate care facility/developmentally disabled habilitative

  Intermediate care facility/developmentally disabled

  Intermediate care facility/developmentally disabled-nursing

- In 2009, subdivision (m) was added to section 1250 of the Health and Safety Code (AB 1540, statutes of 2009) for:

  Intermediate care facility/developmentally disabled-continuous nursing (ICF/DD-CN)

Home Care

It wasn't until the 1960s that home health care was included in the Medicare, Medicaid, and Old Age Assistance Act. But because those creating the guidelines assumed there were family members who would be subsidizing home health care needs, coverage for home health care was mandated only for medically necessary, intermittent care for those acutely ill patients who had been released from the hospital. By the 1990s, however, changes within varying levels of government allowed for expansion of home health services, but it didn't last. The Balanced Budget Act of 1997 drastically slashed Medicare home benefits, and as a result, the number of patient visits were reduced, and 3000 home care agencies shut down.[2]

JUSTIFICATION

The proposed legislation addresses the immediate need to ensure patients are not in jeopardy of being reinstitutionalized by providing additional carve outs to allow LVNs with appropriate training to practice respiratory care in home and community-based settings. This proposal also requests further exploration into the root of the existing problems and how to address them to prevent consumer harm.

ARGUMENTS PRO & CON

Pro: The legislative proposal alleviates fears of patients and providers to ensure existing practices continue and lives are not disrupted, and businesses are not displaced. The proposal also aims to explore the crux of the problem so that improvements for consumer safety and patient outcomes may be made in the future.

Con: The unknown cases of respiratory-patient harm that may occur by failure to have access to fully educated, trained and competency tested RCPs.

PROBABLE SUPPORT & OPPOSITION

Likely Support: California Society for Respiratory Care (CSRC)
California Association of Medical Product Suppliers (CAMPS)
Patients, family, and patient advocates
Home and Community-Based Facilities
Service Employees International Union-United Healthcare Workers West (SEIU-UHW)

[2] https://www.24hrcares.com/blog/brief-history-home-care-industry/

Unknown: California Department of Public Health (CDPH)
California Department of Health Care Services (CDHCS)
Department of Social Services (DSS)
Department of Developmental Services (DDS)
Board of Vocational Nursing and Psychiatric Technicians (BVNPT)
California Nursing Association (CNA)

FISCAL IMPACT

This proposal has minimal fiscal impact. The Board will be able to absorb the workload associated with drafting regulations and implementing provisions.

The fiscal impact on the CDPH, CDHCS, DSS and DDS are unknown. The Board is unaware if there are existing staff available to collect and report data.

ECONOMIC IMPACT

This proposal negates the possibility of a significant economic impact to businesses and consumers. This proposal aligns the law with the existing wide-spread practice occurring in these home and community-based settings. It is surmised there will be a smaller economic impact associated with training and educating LVNs once standard guidelines are established. These costs will be mitigated by existing costs for those companies who expend resources currently to train LVNs to perform respiratory care.

FINDINGS FROM OTHER STATES

A handful of states were found that allow Licensed Practical Nurses (LPNs), the equivalent of LVNs, to perform limited care for ventilator patients including changing a trach dressing, suctioning, and changing ventilator circuits upon completion of initial and annual renewal training and with adequate supervision in home and community-based settings. None of these states permitted LPNs to perform deep suctioning, adjust ventilator settings or any task requiring independent assessment.

Several states also noted a requirement that RCPs be available as needed to meet the needs of long-term ventilator dependent residents in facilities that are equivalent to home and community-based facilities in California.

PROPOSED TEXT

Business and Professions Code

3765.

This act does not prohibit any of the following activities:

(a) The performance of respiratory care that is an integral part of the program of study by students enrolled in approved respiratory therapy training programs.

(b) Self-care by the patient or the gratuitous care by a friend or member of the family who does not represent or hold themselves out to be a respiratory care practitioner licensed under the provisions of this chapter.

(c) The respiratory care practitioner from performing advances in the art and techniques of respiratory care learned through formal or specialized training.

(d) The performance of respiratory care in an emergency situation by paramedical personnel who have been formally trained in these modalities and are duly licensed under the provisions of an act pertaining to their specialty.

(e) Temporary performance, by other health care personnel, students, or groups, of respiratory care services, as identified and authorized by the board, in the event of an epidemic, pandemic, public disaster, or emergency.

(f) Persons from engaging in cardiopulmonary research.

(g) Formally trained licensees and staff of child day care facilities from administering to a child inhaled medication as defined in Section 1596.798 of the Health and Safety Code.

(h) The performance by a person employed by a home medical device retail facility or by a home health agency licensed by the State Department of Public Health of specific, limited, and basic respiratory care or respiratory care related services that have been authorized by the board.

(i) The performance, by a vocational nurse licensed by the Board of Vocational Nursing and Psychiatric Technicians of the State of California, who is employed by a home health agency licensed by the State Department of Public Health of respiratory tasks and services identified by the board, if the licensed vocational nurse complies with the following:

(1) Before January 1, 2025, the licensed vocational nurse has completed patient-specific training satisfactory to their employer.

(2) On or after January 1, 2025, the licensed vocational nurse has completed patient-specific training by the employer in accordance with guidelines that shall be promulgated by the board no later than January 1, 2025, in collaboration with the Board of Vocational Nursing and Psychiatric Technicians of the State of California.

(j) Licensed vocational nurses providing respiratory tasks and services identified by the board at a licensed Adult Day Health Care facility, a licensed Pediatric Day Health & Respite Care facility, a licensed Congregate Living Health Facility, a licensed Intermediate Care Facility or as part of daily transportation and activities, if the licensed vocational nurse complies with the following:

(1) Before January 1, 2026, the licensed vocational nurse has completed patient-specific training satisfactory to their employer.

(2) On or after January 1, 2026, the licensed vocational nurse has completed patient-specific training satisfactory to the employer and maintains a current and valid certification of competency from the California Association of Medical Product Suppliers or the California Society for Respiratory Care for tasks performed in accordance with guidelines that shall be promulgated by the board no later than January 1, 2026.

~~(j)~~ (k) The performance of pulmonary function testing by persons who are currently employed by Los Angeles County hospitals and have performed pulmonary function testing for at least 15 years.

HEALTH AND SAFETY CODE
DIVISION 1. ADMINISTRATION OF PUBLIC HEALTH

136.

(a) The California Department of Health Care Services and the California Department of Public Health, with cooperation from the Department of Developmental Services and the Department of Social Services, shall report to the appropriate fiscal and policy committees of the Legislature by June 30, 2025, the following:

1) For each of the three prior years, and as it relates to each Adult Day Health Care facility, Pediatric Day Health & Respite Care facility, Congregate Living Health facility, and Intermediate Care facility the following:

   A) The number of events where patients were transported to another facility to receive emergency care and

   B) The total annual costs by reimbursement code and its definition and dollar amount, for all costs associated with patient transport for emergency care and the emergency care itself.

2) An analysis, including the impact and existing barriers, of amending existing laws and regulations to:

   A) Establish a reimbursement code for respiratory therapists employed by a licensed Home Medical Device Retailer, performing mask fitting, equipment installation and maintenance, instruction in the use of respiratory equipment and follow up services, consultation, and education visits, separate from reimbursement for medical equipment itself.

   B) The analysis shall include the impact to patient care if follow up services, and consultation and education visits, not required by law, were no longer provided.

3) An analysis, including the impact and existing barriers, of amending existing laws and regulations to:

A) Establish reimbursement for one RCP to be on staff to provide oversight and services at home and community-based settings for every 6 beds and

B) Include respiratory care practitioners in meeting the overall nursing ratios required in home and community-based settings.

4) An analysis, including the impact and existing barriers, of amending sections 58013 and 51523 of Title 22 to include respiratory therapy services provided by respiratory care practitioners. The departments shall consult with the Respiratory Care Board to identify respiratory therapy services.

5) Feasibility of replacing terms of respiratory technician, respiratory therapist, or any deviation thereof, with respiratory care practitioner in Title 22.

6) Studies conducted or data collected by any department demonstrating that access to respiratory therapists reduces health care costs.

b) This section shall remain in effect only until January 1, 2026, and as of that date is repealed.